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# Who will service the Debts of defunct PCTs

Alison Moore<sup>1</sup> *Public Finance* 28 January 2011

**Primary care trusts are in the exit lounge as ministers prepare to hand over NHS commissioning powers to GPs. But with many trusts heading for the red – and waiting times and rationing on the rise – could creating the new consortiums be putting patient care at risk?**

In just over two years, primary care trusts will cease to exist and GP commissioning consortiums will be in control of NHS finances. As Health Secretary Andrew Lansley pushes forward with his plans to hand power to GPs, there is growing concern from the Treasury about cost control.

The Health & Social Care Bill, published in January, will fundamentally alter the NHS landscape. It has had a very cautious – if not outright hostile – reception from many in the health sector.

But as the politicians wrangle, PCTs are struggling to stay within budget. Some have significantly overspent with both their NHS and private providers.

Contingency funds are being raided, and although many still forecast a surplus or a breakeven position, this is often conditional on large savings being found in the last few months of the financial year.

NHS Eastern & Coastal Kent, for example, is expected to be as much as £25.6m over budget on commissioning. It has only been able to forecast a surplus, through using contingency funds and finding 'unidentified' savings.

NHS North Yorkshire & York is just under £20m overspent, and the figure is predicted to rise to £28.4m by the end of the financial year.

Other problems include increased demand for elective and planned treatments. Even where this is contained, the costs have risen. The flu outbreak over the past few weeks – and subsequent heavy demand for intensive care beds – will have added to the pressures. Many PCTs have taken emergency measures to try to bring their budgets into balance. Lists of 'low priority procedures' have been extended so that patients are increasingly unlikely to get funding for certain treatments.

Thresholds for more mainstream treatments are also being changed, with less expensive - interventions being tried before surgery.

PCTs say these approaches are justified on clinical grounds but can also save money. NHS Portsmouth City, for example, expects to save £500,000 a year by changing the weight threshold for orthopaedic patients. Those with a Body Mass Index of over 35, rather than 40, will now be expected to try to lose weight before surgery.

Procedures for weight loss, infertility and gender reassignment are being deferred in many parts of the country. And so are cataracts, hip replacements and hysterectomies in some areas.

Health select committee chair and former Conservative health secretary Stephen Dorrell is one of many who questions whether these measures make long-term sense: 'If you do two cataracts on the same patient on the same day then it is cheaper than doing them on two - separate days,' he told *Public Finance*.

PCTs have introduced savings plans but their calculations have been thrown by increasing cost pressures. NHS Surrey announced a series of cost-cutting measures in November, despite having made significant savings earlier in the financial year. Rising cost pressures in-

year meant that it risked a £35m deficit.

King's Fund chief economist John Appleby points out, the NHS settlement for 2010/11 represented very little growth, and PCTs' allocations were top-sliced by their strategic health authorities.

PCT Network director David Stout says: 'We have been used to living with extra funds. As soon as you go from 3% extra a year to 0.5% extra, it gets difficult.'

The big money saver for PCTs is deferring non-urgent procedures until the next financial year or through lengthening waiting times.

NHS South West Essex hopes to save £8.4m this year by increasing waiting times. It's currently forecasting a £16.7m overspend but still aims for breakeven at the end of the financial year.

The 18-week 'referral to treatment' standard, enshrined in the NHS Constitution, could be endangered by deliberately lengthening waiting times – to as long as 16 weeks in NHS Eastern and Coastal Kent – leaving little margin for anything to go wrong. It also makes it hard for PCTs to return to shorter waiting lists.

Dawn Scrafield, finance director at NHS SW Essex, believes that the longer waiting times her organisation has instigated will remain into the next financial year: the PCT won't have the money to reduce them again. It has a £52m turnaround plan, was £15.5m in deficit by the end of October and forecasts a year-end deficit of £16.7m. A significant proportion of identified savings are 'high risk' and 62% of them will be found in the last quarter of the year.

But PCTs will have to make these improvements as they reduce management costs and, inevitably, staff. Mr Dorrell suggests some might have 'averted their eyes' to looming problems earlier in the year, leaving them with more to do in a few months – and at a time when their management capabilities have been reduced as organisations cut management costs by 46%.

Some managers have left under the mutually agreed resignation scheme and many PCTs are reluctant to fill vacancies when they anticipate having to make significant redundancies. The growth of PCT 'clusters' over the next few months could reduce managers' numbers further.

What does the future hold for PCT finances as they head towards abolition? Continued pressure seems certain: the trusts will get a 2.2% uplift for 2011/12, excluding money for social care, which is lower than the Department of Health's estimate of likely inflation pressures.

PCTs will gain from reductions in the payment by results tariff from 2011/12 but this will be largely cancelled out by a 2% retention of funds by SHAs, which will be released only if PCTs make a business case for needing them to fund changes.

Longer term, the DoH is offering the possibility of more locally negotiated pricing – below the tariff – which could bring greater savings if providers are prepared to step forward and do the work for less money. This could shift some of the financial pressure on to providers but will add to management burdens.

GP consortiums won't inherit any of the debts from this financial year – which might create contradictory pressures for finance directors. GPs may prefer the debts to be incurred now rather than in 2011/12.

From April there is likely to be intense pressure for PCTs to cut costs and come in on budget. Getting GPs involved in commissioning decisions even before consortiums take over the reins is seen as important.

GP commissioners might have different levers to PCTs to control costs – including a greater power to influence their colleagues and to devise different pathways with hospital doctors.

But where power has been devolved downwards to GPs already, there have been fairly modest savings although services might have improved. One recent analysis of 190 practice-based consortiums showed an average 2.5% 'overspend'.

Consortiums will not only have to commission better and improve productivity upwards but to disinvest and be prepared to close facilities.

Mr Stout believes that the multiple routes into hospital make controlling demand harder – patients can always self-present at accident & emergency departments. He says reducing facilities might have to be part of the solution: 'If you leave facilities open, they tend to fill.' PCTs that have invested in community services to reduce demand on acute sectors – only to find they were left with double running costs as demand for both services remained high – may have to disinvest.

Stephen Dorrell points to the demands for savings across the whole NHS: 'It's 4% efficiency gains compounded over four years. It's an unprecedented challenge but we have to try.' Putting GPs in charge of commissioning decisions might not be the panacea for the financial ills of the NHS: expect more pain to come.

1. <http://www.publicfinance.co.uk/features/2010/12/accident-waiting-to-happen/>